

PHYSICAL EXAMINATION REPORT
AMATEUR KICKBOXER or MIXED MARTIAL ARTIST
☐ MALE ☐ FEMALE

3. Hepatitis C Antibody - If positive confirmation by qualitative PCR (polymerase chain reaction)

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EYE HISTORY: Has applicant ever had any of the following conditions:

- (1) Blurred vision ? ☐ Yes ☐ No
- (2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye ? ☐ Yes ☐ No
- (3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens ?
☐ Yes ☐ No

YOU MUST ALSO GO TO AN OPHTHALMOLOGIST FOR A DILATED EYE EXAM FOR LICENSURE

EXAMINING PHYSICIAN: - The following section must be completed.

I have evaluated the above named athlete and ordered the requested exams. Listed are any significant abnormalities either in my physical or the testing. Also listed are the steps I took to clarify any problem.

PLEASE CHECK ONE: I HAVE ☐ HAVE NOT ☐ MEDICALLY CLEARED TO FIGHT

_____ LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print)			_____ PHYSICIAN'S SIGNATURE
_____ STREET ADDRESS			_____ DATE
_____ CITY STATE ZIP CODE			() _____ PHONE NUMBER

APPLICANT:

I declare under penalty of perjury under the laws of the State of Nevada, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Athletic Commission of the Department of Business and Industry of the State of Nevada (the "Commission"), pursuant to the provisions of NRS/NAC Chapter 467, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in any of the Commission's records. I further authorize the Commission to release this information to any person whom the Commission determines has a need to know. I agree that I will fully cooperate with the Commission in making my medical history available including, but not limited to, giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE the Commission on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Commission on the basis of its disclosures. I have signed this Release voluntarily and of my own free will.

I further agree that a photographic copy of this Authorization shall be valid as the original.

_____ DATE	_____ SIGNATURE OF APPLICANT
_____ LOCATION	_____ NAME PRINTED